Methodological Issues in Evaluating HIV Prevention Community Planning

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SYNOPSIS

TO BE EFFECTIVE, HIV PREVENTION PROGRAMS should be planned in partnership with affected communities and should be built on a solid scientific foundation. In 1994, the Centers for Disease Control and Prevention (CDC) and its prevention partners implemented HIV prevention community planning to achieve primarily these two objectives. In order to manage the community planning process effectively, extensive evaluation activities were employed at both the grantee and national level. This paper describes the first year evaluation goals and methods in detail. Throughout, reasons for collecting specific types of information and for using particular methodologies are highlighted.

Sixty-five health department grantees are awarded funds under the Centers for Disease Control and Prevention's (CDC) Program Announcement 300 to carry out HIV prevention activities in their jurisdictions. These grantees include the 50 states, 8 U.S. territories, the District of Columbia, and 6 local health departments (Chicago, Houston, Los Angeles, New York City, Philadelphia, and San Francisco).

Since 1986, CDC has provided guidance regarding the use of Federal HIV prevention funds which encouraged grantees to involve members of their communities in planning HIV prevention efforts. However, resource limitations made this type of participatory planning difficult for grantees. In addition, legislative language regarding HIV prevention funds required grantees to commit a certain proportion of their resources to specific program activities (for example, counseling and testing), thus diluting the possible impact of a comprehensive planning process.

In 1993, Congress took action in two specific areas to encourage the implementation of comprehensive community planning for HIV prevention programs. First, the language requiring that a certain proportion of the prevention funds be allocated to specific program activities was removed. Second, funds were appropriated to support the implementation of comprehensive planning.

In 1994, CDC provided direct support to grantees for HIV prevention community planning. A total of $12 million was allocated to the 65 grantees

to implement the new planning process. These new resources, and others, were used to support community planning group meetings and processes, and to provide the necessary technical support to the effort through use of outside facilitators and additional health department capacity.

Numerous governmental and nongovernmental organizations assisted in the design of HIV prevention community planning, including the National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Association of People With AIDS (NAPWA). Draft guidance was prepared and input was received from a variety of sources, including a public meeting convened on November 15, 1993. The result of this comprehensive, participatory effort was that on December 30, 1993, CDC issued the *Supplemental Guidance on HIV Prevention Community Planning* to State, territorial, and local health department grantees.

Evaluating community planning is also useful to both CDC and grantees in that it contributes to a beneficial iterative process.

This guidance provides the basic parameters of the planning program through which health departments across the nation now share responsibility for determining HIV prevention program priorities with the affected communities in their jurisdiction. The planning process also is designed to enhance the scientific evidence basis of HIV prevention programs. We believe that the attainment of the two objectives (participation by affected groups and application of a sound scientific basis) will contribute to the improved effectiveness of prevention programs in halting the spread of HIV disease *(1)*.

Although the *Supplemental Guidance on HIV Prevention Community Planning* established the basic parameters of the planning program, it did not prescribe the exact planning structure to be implemented in each jurisdiction. In this way, grantees can confer with their community and determine the best approach to HIV prevention community planning for their area.

In general, the health department and community planning group(s) are responsible for conducting a participatory process that results in the development of a comprehensive HIV prevention plan. The supplemental guidance suggests the following steps for the planning process:

1. Assess the extent of the epidemic
2. Assess existing prevention resources
3. Identify unmet HIV prevention needs
4. Define the potential impact of specific intervention strategies
5. Prioritize HIV prevention needs
6. Develop a comprehensive HIV prevention plan
7. Evaluate the planning process

Developing the Evaluation Plan

Why should the community planning process be evaluated? As stated previously, the supplemental guidance on community planning points out to grantees the importance of evaluating the process. The portion of the guidance relevant to such an evaluation was Section D, #13 (page 7), which states, "The HIV Prevention Community Planning process includes the following evaluation components throughout the course of the project period: (a) developing goals and measurable objectives for the planning process; (b) monitoring the objectives; (c) evaluating the operation of the process; (d) evaluating the impact of the planning process; and (e) assessing the cost of the process."

Evaluating community planning also is useful to both CDC and grantees in that it contributes to a beneficial iterative process. In other words, by utilizing evaluation strategies and feedback, the community planning process can be improved through the elimination of barriers and the enhancement of facilitating factors.

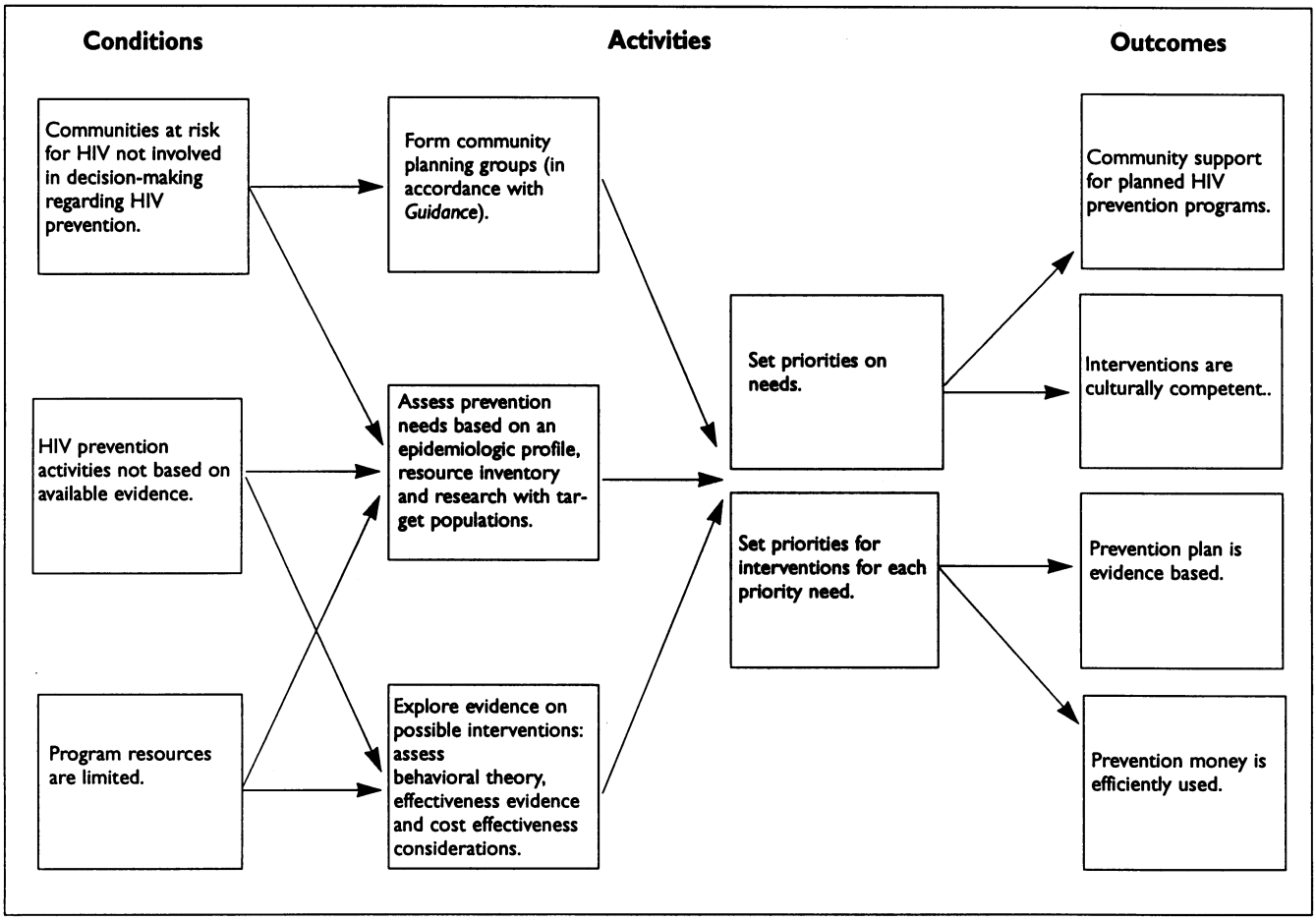
Evaluating the community planning process. This paper describes three steps that were followed to design an evaluation of the community planning process (CPP) for year one: (a) defining the goals of the evaluation; (b) completing a logic model of the community planning process; and (c) creating an evaluation plan by defining process and outcome objectives and possible ways to measure each.

I. Defining the Evaluation Goals. The first step in evaluating the CPP was to determine why it is desirable to do so. What would be gained from conducting such an evaluation? The following three goals were suggested, and grantees were encouraged to explore additional goals that would benefit their planning process:

1. Document that the CPP has actually taken place (through process evaluation);
2. Determine whether or not the program goals of community planning are being met (through outcome evaluation); and
3. Identify strengths and weaknesses in the CPP (through both process and outcome evaluation).

II. Draw a Logic Model of the Community Planning Process. Once the goals of the evaluation were defined, the next step was to use a planning and evaluation tool called a logic model. In general, a logic model is a graphic representation of an intervention. The purpose of doing a logic model was to show the logical connections between condi-

Logis Model for HIV Prevention Community Planning



tions that demonstrated the need for the CPP, the activities aimed at addressing these conditions, and the outcomes that were expected to result from these activities *(2-4)*. One benefit of completing a logic model was that it facilitated the design of an evaluation plan.

To create a logic model, three columns were completed:

1. **Conditions (or problems)** - what the CPP was designed to change, the conditions with which we were dissatisfied;
2. **Activities** - components of the CPP which were being undertaken to solve the problem; and
3. **Outcomes** (short-term program goals) - immediate changes we anticipated as a result of the CPP.

Once the columns of the logic model were completed, arrows were drawn to link the components of the three columns. Figure 1 shows the logic model of the community planning process. Grantees were encouraged to add their own ideas to each column. Short-term outcomes are expected to lead eventually to the long-term outcomes of reductions in risky behaviors and, thereby, HIV transmission.

III. Develop the Evaluation Plan: Defining & Measuring Program Objectives. The third step in evaluating the CPP was to create an evaluation plan by identifying process and outcome objectives, as well as possible strategies for measuring them. Both the evaluation goals and the logic model arrived at in steps I and II were used to form the evaluation plan.

Meeting Evaluation Goal 1. As was discussed previously, the first goal of the evaluation was to document through process evaluation that the CPP has actually taken place as planned. To draw conclusions about the CPP, CDC and the grantees must first ensure that community planning was carried out as designed.

The specific process objectives related to the first evaluation goal were derived from column 2 of the logic model (Activities). Careful monitoring and documentation of these community planning activities could serve as data for a process evaluation. Box 1 presents a list of the process objectives arrived at from the logic model, as well as suggested measures for each of the objectives. Again, grantees could incorporate additional objectives and measures that they felt were appropriate.

Meeting Evaluation Goal 2. The second evaluation goal was to determine whether or not the short-term program goals or outcomes were being met. Specific outcome objectives were developed from column 3 of the logic

Process Objectives for HIV Prevention Community Planning, Year One

Activity 1: Form and involve the community planning groups (CPGs) in accordance with the guidance

Process objectives for Activity 1:

P1a) Ensure that the nomination for CPG membership is an open process
Measured by: Written policy on nomination process

P1b) Provide CPG members with a formal statement of their roles and responsibilities as outlined in the Guidance
Measured by: Orientation plan for CPG members which includes information on their roles and responsibilities, and documentation that this orientation took place

P1c) Create specific policies and procedures for resolving conflict within the CPG
Measured by: Written policies and procedures for conflict and dispute resolution

P1d) Ensure that the CPG reflects in its composition the characteristics of the current and projected epidemic in its jurisdiction
Measured by: Roster of CPG members and what group(s) within the community they each represent

P1e) Ensure that the CPP is open, candid, and participatory
Measured by: Written procedures for conducting meetings
Measured by: Meeting attendance records

Activity 2: Assess needs

Process objectives for Activity 2:

P2a) Assess the present and future extent, distribution, and impact of HIV/AIDS
Measured by: Records of a completed epi profile

P2b) Assess current HIV prevention in the community
Measured by: Records of a completed services profile

P2c) Determine the correspondence between the needs identified in the epi profile and the HIV programs available in the services profile to identify unmet needs (called the Gap Analysis)
Measured by: Records of a completed Gap Analysis

P2d) Assess community opinions
Measured by: Records of community members asked about HIV needs as part of the needs assessment

Activity 3: Prioritize unmet needs

Process objectives for Activity 3:

P3a) Ensure that priority setting of needs is shared between community members and organizations that administer and award HIV prevention funds
Measured by: Attendance at CPG meetings when prioritization of needs was discussed

P3b) Base prioritization of needs on epidemiologic profile, services profile, gap analysis, and community input
Measured by: Procedure for prioritizing needs
Measured by: List of unmet needs developed through the prioritization process

Activity 4: Explore available evidence regarding possible interventions

Process objectives for Activity 4:

P4a) Consider effectiveness
Measured by: Review of literature demonstrating effectiveness of similar programs
Measured by: Estimation of probable effectiveness when nothing exists in the literature and there has been no program experience to date
Measured by: Meeting notes when effectiveness was discussed

P4b) Consider behavioral and social science theory
Measured by: Theory basis of proposed interventions
Measured by: Meeting notes when theory was discussed

P4c) Consider cost-effectiveness
Measured by: Review of literature demonstrating cost-effectiveness of similar programs
Measured by: Estimation of probable cost-effectiveness when nothing exists in the literature and there has been no program experience to date
Measured by: Meeting notes when cost-effectiveness was discussed

P4d) Consider prior program experience
Measured by: Evidence of effectiveness and cost-effectiveness of similar programs conducted in the community which has not been published in the literature
Measured by: Meeting notes when prior program experience was discussed

P4e) Consider community opinions
Measured by: Records of community members asked about acceptable/appropriate HIV prevention programs

ACTIVITY 5: Prioritize Interventions

Process Objectives for Activity 5:

P5a) Ensure that priority setting for interventions is shared between community members and organizations that administer and award HIV prevention funds
Measured by: Attendance at CPG meetings when prioritization of interventions was discussed

P5b) Base prioritization of interventions on list of unmet needs, effectiveness, cost-effectiveness, theory, and community norms and values
Measured by: Procedure for prioritizing interventions
Measured by: List of interventions developed through the prioritization process

model. Box 2 lists possible outcome objectives and measures; again, grantees were encouraged to expand this list where appropriate.

Meeting Evaluation Goal 3. The third evaluation goal was to identify weaknesses and strengths in the CPP through process and outcome evaluation. For example, if most of the community planning groups were having difficulty achieving a certain process objective, then this objective should be reconsidered. It may be that the objective was not clear enough, it was unreasonable, or more technical assistance was required.

Translating the evaluation plan into action. As stated previously, the guidance required that grantees evaluate the community planning process. The objectives and suggested measures described in the previous section and presented in

tables 1 and 2 were suggested to grantees as possible ways to conduct such an evaluation.

While this "grantee-level" evaluation is imperative for local management of community planning, it does not yield much information on community planning as implemented nationwide. Therefore, CDC undertook several additional evaluative activities; these are described briefly in subsequent sections.

Core Objectives

A national assessment of community planning does not require measurement of all process and outcome measures that might be useful at a local level. Therefore, five core objectives were identified. These are listed in table 3. Although there are many other facets of community planning, these five core objectives relate to the central defining features of community planning. Each grantee was asked to report on these five core objectives when submitting an application for continued funding on October 3, 1994. CDC (with assistance from the Academy for Educational Development) compiled this reported information and distributed a report in March 1995. This provided a national "snapshot" of first year progress in these five areas and suggested areas in need of most attention in years 2 and beyond of HIV prevention community planning.

Budget Tracking

In 1994, CDC modified its budgetary reporting requirements for grantees' continuing funding applications. Rather than focus on detailed program operation budgets, CDC shifted the focus to more population- and intervention-oriented budgetary information. Hence, grantees now provide information on planned expenditures as categorized by prevention intervention type, population served, and so on. (Of course, actual expenditures ultimately may differ somewhat from planned expenditures.) This information will provide much more detail on the exact types of programs being funded, and will allow for the monitoring of trends in spending by these budget categories over time. Further, this change allows CDC to answer in a meaningful and detailed fashion the question, "Has community planning led to a change in spending patterns?" Note that this question is not "Has Community Planning lead to optimal spending patterns?"

Case Studies

CDC contracted with the U.S. Conference of Mayors (USCM) to carry out case studies in nine sites, and with Battelle Memorial Institute to conduct similar case studies in two sites. USCM and Battelle could conduct the case studies without conflict of interest, since these independent groups of evaluators had not been previously involved in the HIV prevention community planning process. A 13-member technical advisory board was created to assist USCM in the design of the case study component of the evaluation. The technical advisory board contained representatives of State health departments, local governments, nongovernmental community members, and persons with expertise in community planning, HIV-AIDS, and evaluation methods.

All 65 grantees were eligible for this study. A set of site-selection criteria was developed by USCM and the technical advisory board (for example, statewide vs. regional planning groups, recent numbers of AIDS cases, amount of Federal funds received for HIV prevention interventions, amount of Federal funds received for HIV prevention community planning). Using these site-selection criteria, sites chosen for case studies were Arizona, Florida, Indiana, Kansas, Maine, New York State, Oregon, Puerto Rico, and the local health departments in Chicago, Los Angeles, and Washington, DC.

Key evaluation questions were developed for the case studies which embodied the five core objectives already described and allowed for a more in-depth look at the plan-

Outcome Objectives for HIV Prevention Community Planning, Year One

Short-Term Goal 1: Community will support the comprehensive HIV prevention plan

Outcome Objectives for Short-Term Goal 1:

O1a) Utilize input from the CPG to create the comprehensive plan
Measured by: Letters of concurrence and non-concurrence from the community planning groups (CPGs).

Short-Term Goal 2:
Interventions in the comprehensive plan will be culturally competent

Outcome Objectives for Short-Term Goal 2:

O2a) Utilize input from the community opinion survey to create the comprehensive plan
Measured by: Concordance between acceptable interventions, as expressed in the assessment of community values and norms, and the comprehensive plan

Short-Term Goal 3: Comprehensive plan will be based on available evidence

Outcome Objectives for Short-Term Goal 3:

O3a) Base comprehensive plan on results of needs assessment and exploration of the literature.
Measured by: Logic model of the comprehensive plan

Short-Term Goal 4: HIV prevention funds will be utilized more efficiently

Outcome Objectives for Short-Term Goal 4:

O4a) Conduct a thorough budget analysis of funds received
Measured by: Comparison of how funds were spent during the past year with how they will be spent this year

O4b) Facilitate sharing of resources between HIV prevention providers in the community to decrease duplication of efforts
Measured by: Evidence of coordination between agencies (such as letters of agreement, joint programs, sharing of personnel)

Core Objectives for HIV Prevention Community Planning, Year One

1. Ensure that the nomination for community planning group (CPG) membership is an open process
   Measured by: Written policy specifying an open and inclusive nomination process
2. Ensure that the CPG reflects in its composition the characteristics of the current and projected epidemic in its jurisdiction
   Measured by: Roster of CPG members and what group(s) with in the community the planning group represents (individual names need not be listed; rather the collective representation of the planning group could be profiled)
3. Base prioritization of needs on epidemiologic profile, resource inventory, gap analysis, and research on target populations
   Measured by: Procedure for prioritizing needs
   Measured by: Review of unmet needs and justification of priority needs
4. Base prioritization of interventions on list of unmet needs, effectiveness, cost-effectiveness, theory, and community norms and values
   Measured by: Procedure for prioritizing interventions
   Measured by: Review of interventions and justification of priority interventions
5. Develop the HIV prevention funding application based on the community plan
   Measured by: Letters of concurrence or nonconcurrence from the community planning groups

ning process. The evaluation areas to be explored in the case studies were inclusion and representation in the process, parity and technical assistance, the development of the comprehensive HIV prevention plan (including the epidemiologic profile, needs assessment, and priority-setting processes), the overall process used for the HIV prevention community planning effort, and lessons learned that could inform and improve community planning in future years. In addition to these evaluation questions, the case studies conducted by Battelle focused on special challenges that community planning poses for city grantees (as distinct from States or territories).

HIV prevention community planning holds tremendous promise for improving HIV prevention programs.

After the framing of the questions, evaluation methods and instruments were selected *(5)*. The methods included observation of community planning group meetings, review and content analysis of documents developed in jurisdictions, focus groups of community planning group members, and structured formal interviews with community planning co-chairs, group members, and interested persons who are not members of community planning groups. Case study data were collected by USCM in each site during the study period, August 1-November 30, 1994; the Battelle case studies were conducted on a slightly different timeline, and field work ended in January 1995. Results of the case studies of the first year of the HIV prevention community planning initiative were published in Spring 1995.

Informal Assessment of Barriers and Facilitating Factors

CDC has informally assessed barriers and facilitating factors to the progress of community planning. In particular, CDC made it a priority to identify early any problems that arose in community planning and address them directly. This was accomplished by CDC staff paying special attention to the voices of grantees, community planning group co-chairs, community planning group members, and other interested parties. Whenever a problem arose, strategies to address it were identified and implemented. For example, it become clear from these communications that priority setting was a difficult activity for many community planning groups (although no formal survey was done). In response, CDC and the Academy for Educational Development worked with community planning group co-chairs at a meeting in July 1994 to assemble additional helpful information on priority-setting methodologies. This further information was mailed to all grantees in August 1994.

Future Plans

The evaluation methods used to assess progress in community planning will evolve and mature over time along with the continued evolution of community planning itself. CDC has begun to plan for evaluation activities in years 2 and beyond of community planning. A major milestone in this planning was a national meeting December 5-7, 1994. This meeting drew from multiple information sources to assess the current status of community planning (many of these information sources are derived from the evaluation activities described previously). One workshop in this meeting was devoted exclusively to (a) revisiting the evaluation methods used in year 1, and (b) working with prevention partners to refine plans for evaluation activities in year 2. The feedback from this meeting was compiled at CDC. Other evaluation activities being undertaken by CDC are beyond the scope of this paper to describe. In order to finalize evaluation plans for year 2 and beyond, CDC must determine whether the methods used in year 1 yielded sufficiently useful information for managing the community planning process, and

whether other methods would yield more actionable information in more efficient ways.

Additionally, other prevention partners are conducting their own evaluations of community planning. For instance, the AIDS Action Foundation secured private funding to conduct its own case studies of HIV prevention community planning activities.

Conclusion

HIV prevention community planning holds tremendous promise for improving HIV prevention programs. This will be achieved via extensive community involvement in priority setting and the use of the latest scientific findings to guide the decision-making process. Although promising, community planning must be subjected to rigorous evaluation that will provide feedback on the attainment of community planning objectives. Additionally, the evaluation process will allow both CDC and grantees to monitor progress continually and make the necessary adjustments to improve the chances that community planning will indeed improve HIV prevention efforts in the United States. This paper has described in detail the evaluation methods used in year 1 of the community planning process. These methods will grow and mature along with the community planning process itself.

Note: In spring 1994, CDC delivered to its health department grantees a 3-ring binder of technical assistance materials. Included in that binder was a document on evaluation concepts to be used by grantees to help evaluate their local community planning process; that evaluation document was authored by Dr. Janet Harrison. Portions of it have been adapted in segments of this paper.

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